

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009310

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2479

STATE FILE NUMBER

FILED MAR 8 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in lb		c. CITY OR TOWN	
St. Louis, Missouri.		42 years		St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3426 Wyoming Street.,				3426 Wyoming Street.,	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Middle Last Walter Swain Rouse			Month Day Year March 2, 1963		
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days Hours Min.
Male	White		1/24/1879	84	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
Retired Conductor		Public Service Co.		St. James, Missouri.	
12. CITIZEN OF WHAT COUNTRY		U.S.A.			
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
Oren S. Rouse		Frances Sawyer		Ollie Rose, Dec'd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
No Nil				Mrs. Geraldine Jones, 3426 Wyoming St.,	
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a)					
Microcystic Disinfection					
Interval between ONSET and DEATH					
2 days					
Arterial Sclerosis					
5 yrs.					
Nephritic Interstitial					
3 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour s.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from		21. I attended the deceased from			
Jan 2 - 62		to March 2, 63 and last saw him alive on March 1, 1963.			
Death occurred at		3:00 A. M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title)		22b. ADDRESS		22c. DATE SIGNED	
Scott Newen M.D.		6500 Chippewa		March 1963	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Removal		3/5/63		Cedar Grove Cemetery	
23d. LOCATION (City, town, or county)		23d. LOCATION (City, town, or county) (State)			
Salem, Missouri.					
24. FUNERAL DIRECTOR		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
Albert H. Hoppe, Inc., 4700 Washington Blvd.,		MAR 4 1963		Paul Smith M.D.	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.